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State/Territory Name: Maryland

State Plan Amendment (SPA) #:13-17

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #091920134024

April 2, 2014

Charles J. Milligan Jr.
Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Mr. Milligan:

Enclosed is a copy of the approved State Plan Amendment (SPA), Transmittal Number 13-17. This SPA adds Community First Choice 1915(k), to the State Plan.

The effective date for this amendment is January 1, 2014. The signed CMS-179 form and the approved State Plan pages are enclosed.

If you have questions about this SPA, please contact Lieutenant Commander Andrea Cunningham of my staff at (215) 861-4325.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 13-17

2. STATE: Maryland

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Subpart K 441.500 – 441.590

7. FEDERAL BUDGET IMPACT:
a. FFY 2014: $ 10,975 (in thousands)
b. FFY 2015: $ 16,462 (in thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
NEW PAGES - ATT. 3.1K pg 1-23
ATT. 4.19B pg 51-53

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A

10. SUBJECT OF AMENDMENT: Implementation of Community First Choice Program.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Susan J. Tucker, Executive Director
Office of Health Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Charles J. Milligan, Jr.

14. TITLE: Deputy Secretary,
Office of Health Care Financing

15. DATE SUBMITTED: 9/17/13

16. RETURN TO:
Susan J. Tucker, Executive Director
OHS – DHMH
201 W. Preston St., 1st floor
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/17/13

18. DATE APPROVED: APR 02 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JANUARY 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
FRANCIS T. McCULLOUGH

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR

23. REMARKS:
Pen and ink changes requested by State Administrators to add State plan pages to Box 8

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

Notwithstanding anything else in this State plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR §441.510. To receive CFC services and supports under this section, an individual must meet the following requirements:
   1. Be eligible for medical assistance under the State plan;
   2. As determined annually --
      a. Be in an eligibility group under the State plan that includes nursing facility services; or
      b. If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL); and
   3. Receive a determination, at least annually, that in the absence of the home and community-based personal assistance services and supports, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan.
   4. Individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915 (c) requirements and receive at least one home and community-based waiver service per month.
   5. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through other Medicaid State plan, waiver, grant, or demonstration authorities.

B. During the five-year period that begins January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915(k).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Community First Choice State Plan Option

ii. Service Delivery Models

__X__ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

_____ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

____ Direct Cash
____ Vouchers
____ Financial Management Services in accordance with 441.545(b)(1).

__X__ Other Service Delivery Model as described below:

A. The State is offering the Self-Directed Model with service budget – This model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need. Under this model, the State will make available Financial Management Services in accordance with 441.545(b)(1) and has established minimum provider qualifications.

B. Both agency and independent providers will be available for Personal Assistance Services. Participants will have the ability to select the level of self-direction in their Plan of Service (POS). The State will procure a Fiscal Intermediary Management Service, through which participants in the self-directed model with service budget will be able to pay providers and withhold taxes, and participants in both the agency model and self-directed model with service budget will be able to purchase items or services that substitute for human assistance. The fiscal intermediary contractor acts as the fiscal/employer agent on behalf of Medicaid participants enrolled in the self-directed model with service budget for the purpose of managing the payroll tasks for the participant's employees (i.e. personal assistance providers) and for making transactions for transition services, and other items that substitute for human assistance as authorized in the budget within a participant's Plan of Service.

The State will claim an enhanced match on this service.

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iii. Service Package

A. **The following are included CFCO services (in addition to service descriptions, please include any service limitations):**

1.1 Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living, health related tasks through hands on assistance, supervision, and/or cueing, which will be provided under the Personal Assistance (formerly named personal care) Services.

a. Personal Assistance Services means hands-on assistance, supervision, and/or cueing specific to the functional needs of a participant with a chronic illness, medical condition, or disability and includes assistance with ADLs, IADLs and health related tasks as prescribed by§441.520(a)(1). Personal assistance services may include the performance of some delegated nursing functions.

i. Participants will be able to choose between receiving Personal Assistance Services through an agency or a self-directed model with a service budget.

ii. Personal Assistance services will be based on Resource Utilization Groups (RUGs) identified through the interRAI assessment process for determining budgets. The highest RUG grouping budget is $76,360 annually.

iii. There will be a maximum budget for personal assistance services based on RUGs grouping that will help inform supports planners and participants in developing the POS.

iv. There will be an exceptions process, based on medical necessity, for the participants requesting personal assistance services and/or hours above and beyond the recommended budget allotment.

The State will claim an enhanced match for the Personal Assistance Service.

b. Nurse Monitoring - Nurse monitors will give instruction to and evaluate the provision of services of personal assistance providers. This includes the best methods for providing personal assistance as described in the participant's POS.

The State will claim the enhanced match for nurse monitoring that will be provided by the local health departments.

1.2 Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

a. Consumer training –
   i. The topics covered by consumer training may include, but are not limited to money management and budgeting, independent living and meal planning. These activities are to be targeted to the individualized needs of the participant receiving the training; and sensitive of the educational background, culture, and general environment of the participant receiving the training.
   ii. To participate in the Program as a provider of consumer training, a provider shall: be a self-employed trainer or an agency that employs qualified trainers, have demonstrated experience with the skill being taught, and be willing to meet at the participant's home to provide services.

The State will claim an enhanced match on this service.

b. Personal Assistance as described in A.1. Through personal assistance, the participant may work on activities that aid in the acquisition, maintenance, and enhancement of skills.

The State will claim an enhanced match on this service.

c. Items that increase independence or substitute for human assistance as described in B.1. Participants will have access to items that allow for the individual to acquire, maintain, or enhance skills to the extent that expenditures would otherwise be made for the human assistance.

The State will claim the enhanced match for such items that increase independence or substitute for human assistance.

2. Back-up systems or mechanisms to ensure continuity of services and supports.

a. A personal emergency response system (PERS) is an electronic device, piece of equipment or system which, upon activation, enables a participant to secure help in an emergency, 24 hours per day, seven days per week. There are a variety of devices and systems available to meet individual needs and preferences of CFC participants choosing this service.
   i. This service may include any or all of the following components: purchase/installation and monthly maintenance/monitoring of a PERS device. There are different rates established for each of the two components of the PERS service.

ii. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. Units for each type of service are identified separately in the participant's plan of service; units submitted for payment may not exceed what is approved in the participant's POS. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the participant's Plan of Service. The State will claim the enhanced match on this service.

3. Voluntary training on how to select, manage, and dismiss attendants.

a. The State will enter into a Memorandum of Understanding with the Maryland Department of Disabilities to offer this training to participants.
b. This training will be provided to participants when requested and receipt of training and the topics covered will be housed in the tracking system. The Supports Planner will advise the participant of this service and will be able to send an alert in the tracking system directly to MDoD when training is requested. Individuals who self direct can self-refer for this service in the tracking system. Individuals can request a log-in ID from their supports planner and request instruction on how to navigate the system. Even when an individual chooses to waiver supports planning, they will still be assigned a supports planner in the tracking system in the event they need assistance with activities such as help with the tracking system.
c. MDoD will offer training in many formats including: individually, in groups, and by webinar if requested. After completion of training, a record of which topics completed will be added to the client record.
d. Manuals for the training will be developed and provided to participants upon delivery of training and will also be posted in the tracking system for self directing participants to download from the consumer portal.
e. Participants can choose to be referred for training multiple times to complete all of the topic areas of self direction training or enhance their skills.

The State will not claim an enhanced match on this service, but will be covering these services at the administrative claiming rate.

4. Support System Activities

a. Under CFC, the Area Agencies on Aging and supports planning providers identified through a competitive solicitation will engage participants in a person-centered planning process that identifies the goals, strengths, risks, and preferences of the participant. Supports Planners shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community

living. Supports planners shall support applicants in locating and accessing housing options, identifying housing barriers such as past credit, eviction, and criminal histories, and in resolving the identified barriers. Supports planners shall assist the applicant in developing a comprehensive POS that includes both State and local community resources, coordinates the transition from an institution to the community, and maintains community supports throughout the individual's participation in services.

b. In accordance with §441.555 of the CFR, the Supports Planner will:
   i. Appropriately assess and counsel an individual before enrollment; and
   ii. Provide the appropriate information, counseling, training, and assistance to ensure that an individual is able to manage their services and budgets.
   iii. This information must be communicated to the individual in a manner and language understandable by the individual. To ensure the information is communicated in an accessible manner, information should be communicated in plain language and needed auxiliary aids and services should be provided.

c. Also in accordance with §441.555 of the CFR, the POS will include:
   i. Person-centered planning and how it is applied.
   ii. Range and scope of individual choices and options.
   iii. Process for changing the person-centered service plan and, if applicable, service budget.
   iv. Grievance process.
   v. Information on the risks and responsibilities of self-direction.
   vi. Information on the ability to freely choose from available home and community-based personal assistance providers, available service delivery models and if applicable, financial management entities.
   vii. Individual rights, including appeal rights.
   viii. Reassessment and review schedules.
   ix. Goals, needs, and preferences of CFC services and supports.
   x. Identifying and accessing services, supports, and resources.
   xi. Risk management agreements.
   xii. A personalized backup plan.
   xiii. Information on how to recognize and report critical events.
   xiv. Information about how an individual can access a Maryland-based advocate or advocacy system.

The State will claim the enhanced match on this service.

B. The State elects to include the following CFC permissible service(s):

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1. _X_ **Expenditures relating to a need identified in an individual's person-centered POS that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.**

a. The following will be services permissible under CFC in the category of items that substitute for human assistance:

i. Home delivered meals

1. The service can only be provided by a facility or food preparation site that has a food license issued by the local health department, in accordance with COMAR 10.15.03, or an appropriate license from the state in which the site is located.
2. This service will be provided as it substitutes for human assistance and, along with personal assistance, is limited by the RUG allocated budget and there will be the same exceptions process for participants requesting services over the budget.

ii. Environmental Assessments

1. Service must provided by be a licensed occupational therapist, or agency or professional group employing a licensed occupational therapist.
2. The evaluation can be used to determine: the presence and likely progression of a disability or a chronic illness or condition in a participant; environmental factors in the facility or home; the participant's ability to perform activities of daily living; the participant's strength, range of motion, and endurance; and the participant's need for assistive devices and equipment. All of this can be used in the determination of service on the plan of service.

iii. Technology that substitutes for human assistance

1. To participate as a provider of assistive devices, equipment, or technology services, the provider shall be either a Program provider of disposable medical supplies and durable medical equipment under COMAR 10.09.12 or the store, vendor, organization, or company which sells or rents the equipment or system, subject to Department approval during the plan of service review.
2. A unit is equal to one piece of equipment or item.
3. Assistive technology is a device or appliance that empowers a participant to live in the community and/or participate in community activities.

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4. Technology may include a variety of environmental controls for the home or automobile, personal computers, software or accessories, maintenance or repair of technology devices, augmentative communication devices, and self-help aids that assist with activities of daily living and/or instrumental activities of daily living. Additionally, assessments and training may be included as costs under the Technology service.
5. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.
6. Supports Planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed $1,000. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan. When multiple quotes are obtained, the individual shall be permitted to choose the functionality of the technology that best meets the needs as identified in the person-centered service plan.
7. This expense will be capped at $15,000 for every three year period per participant.
8. CFC may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the on-going cost of care or avert institutional care. Units of service may not exceed what is approved in the participant's POS.

The State will claim the enhanced match on these services.

2. __X__ **Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the individual resides.**
   a. This service will be covered as part of CFC. The State will begin covering transition services as part of the fiscal intermediary contract. Transition services will be covered when it is identified based on assessment of need and listed as a needed service in the participant's Recommended Plan of Care.
      i. May not include televisions, television access, or gaming units

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ii. CFC transition funds may be administered via the fiscal intermediary up to 60 calendar days post transition.

iii. Transition services are limited to $3,000 per transition.

The State will claim the enhanced match on these services.

iv. Use of Direct Cash Payments

A. **1.___ The State elects to disburse cash prospectively to CFC participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.**

2.__X__ The State elects not to disburse cash prospectively to CFC participants.

v. Assurances

(A) The State assures that any individual meeting the eligibility criteria for CFC will receive CFC services.

(B) The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFC services.

(C) The State assures the provision of consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(D) With respect to expenditures during the first twelve month period in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section

1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

(E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.

(F) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

- **(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.**
- **(ii) The number of individuals that received such services and supports during the preceding fiscal year.**
- **(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.**
- **(iv) Data regarding how the State provides Community First Choice and other home and community-based services.**
- **(v) The cost of providing Community First Choice and other home and community-based services and supports**
- **(vi) The specific number of individuals that have been previously served under any other home and community based services program under the State plan or under a waiver.**
- **(vii) Data regarding the impact of Community First Choice services and supports on the physical and emotional health of individuals.**
- **(viii) Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care.**

(G) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws and all applicable provisions of Federal and State laws as described in 42 CFR 441.570(d) regarding the following:

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(i) Withholding and payment of Federal and State income and payroll taxes.
(ii) The provision of unemployment and workers compensation insurance.
(iii) Maintenance of general liability insurance.
(iv) Occupational health and safety.
(v) Any other employment or tax related requirements.

(H) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

(I) The State assures that service budgets follow the requirements of 42 CFR 441.560.

vi. Assessment and Service Plan

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences, goals, and other factors relevant to the need for services:

A. The participant has an initial and an annual assessment done by the local health department using a standardized assessment of need.
1. The assessment will be performed face-to-face by a nurse and/or social worker from the Local Health Department. The assessment is entered in the Long Term Service and Supports (LTSS) tracking system.
2. The POS will be completed by a Supports Planner chosen by the applicant/participant.
3. The state establishes conflict of interest standards for the assessments of functional need and the person-centered service plan development process in accordance with 42 CFR 441.555(c).

The State will not claim and enhanced match for these services.

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Indicate who is responsible for completing the assessment prior to developing the Community First Choice person-centered service plan. Please provide the frequency the assessment of need will be conducted.

B. The initial and annual assessments will be conducted by the Local Health Departments or a State contractor. Assessments will be completed upon application to the program to determine initial eligibility and annually to maintain eligibility. A standardized assessment is used to determine service needs.

Describe the reassessment process the State will use when there is a change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:

C. A reassessment based on a change in the individual's needs will be conducted in the same manner and by the same entity as the initial and annual assessment. An assessment for significant change can be requested at any time during a participant's enrolled status in CFC. Per 42 CFR 441.535(c) and 441.540(c), the participant may also request an assessment at any time.

Person-Centered Service Plan Development Process: Describe the process that is used to develop the person-centered service plan, including: Indicate how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.

D. Several entities are involved in the development of the POS with the applicant or participant, including the supports planner and the local health department (LHD) evaluators. After receiving a referral, LHD staff schedule an on-site visit with the applicant to conduct a comprehensive evaluation, including the completion of the standardized assessment instrument. Recommendations in the form of a Recommended Plan of Care are made based on the comprehensive evaluation/assessment.

E. Per 42 CFR 441.540(a)(1), a participant may select from any available supports planner in the jurisdiction. All applicants for Community First Choice will be mailed a package with brochures of available supports planning agencies for their jurisdiction. The applicant or participant will be able to call the Department, the supports planning agency or the local health department to select, which can be then be indicated in the tracking

system. The Supports Planner then schedules and completes a face-to-face meeting with the applicant/participant and their identified representatives to explore the applicant/participant's needs, preferences, strengths, risks, and goals through a person-centered planning process. This will be done by a supports planning agency that has demonstrated the ability to be culturally sensitive in all business practices and effectively relates to the cultural/ethnic diversity of participants. The person-centered planning process shall include people chosen by the individual applicant or participant. The participant can choose a new supports planning agency in the event that they are unsatisfied with their current selection.

F. The Supports Planner will use the tracking system and have access to the clinical assessors' Recommended Plans of Care. With that information along with input from the participant, a Supports Planner will help create a proposed plan of service. Supports Planners will assist the participant in identifying enrolled providers and make referrals for voluntary training on self-direction, when needed.

G. Supports Planners shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community living. Person-Centered Planning is essential to assure that the participant's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the POS. Supports Planners engage every applicant and participant in a person-centered planning process designed to encourage self-direction and offer the participant choice and control over the process and resulting plan.

H. Risk mitigation strategies, including back-up plans that are based on the unique needs of the individual must ensure health and safety while affording an individual the dignity of risk. Individualized risk mitigation strategies are incorporated directly into the POS and are done in a manner sensitive to the individual's preferences. The POS will need to contain a reasonably designed back-up system for emergencies, including situations in which a scheduled provider does not show up to provide services. Strategies may include individual, family, and staff training, assistive technology, back-up staffing, etc. The proposed POS becomes effective upon approval by the Department.

I. The POS will also indicate whether the participant is using an agency model, a self-directing model, or a combination of both models.

J. Per 42 CFR 441.530(a)(1)(ii) the setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and for residential settings, resources available for room and board.

All actions of the aforementioned person centered planning process will comport with 42 CFR 441.540 (b).

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A description of the timing of the person-centered service plan to assure the individual has access to services as quickly as possible, frequency of review, how and when it is updated, mechanisms to address changing circumstances and needs or at the request of the individual.

K. The first day of the process begins when an applicant expresses interest in the CFC program. The referral to the local health department occurs and within 15 calendar days the assessment and Recommended Plan of Care are completed.
L. Supports Planner selection begins when the medical and financial eligibility processes have been completed. A Supports Planning selection packet will be mailed to the applicant at the same time that the referral for medical assessment is made. A person has 21 calendar days to select a Supports Planner or one will be automatically assigned via the LTSS tracking system. The participant may choose at any time to switch to a different available supports planning agency. They can do this by calling the Department, the existing supports planning agency, the supports planning agency of their choice, or the local health department. The Supports Planner has 20 days to submit the POS.
M. Supports Planners and participants will have access to the POS and will have the ability to update and request changes based on significant change or upon request of the individual at any time.

A description of the strategies used for resolving conflict or disagreement within the process, including the conflict of interest standards for assessment of need and the person-centered service plan development process that apply to all individuals and entities, public or private.

N. The process begins with the Local Health Department performing a standardized assessment. The development of the POS is then done by another entity, the Area Agency on Aging or other provider identified through a competitive solicitation. There is a separation of duties such that the same entity will not be performing the assessments and completing the plan of service with the participant.
O. Supports planning entities that have responsibility for service plan development may not provide other direct waiver services to the participant unless there are administrative separations in place to prevent and monitor potential conflicts of interest.
P. Plans of service are reviewed by the Department prior to implementation to assure that there are no conflicts of interest.

vii. Home and Community-based Settings

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CFC services will be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital providing long-term care services, or any other locations that have qualities of an institutional setting.

Please specify the settings CFC services will be provided.

A. CFC services are available and provided to individuals residing in settings that meet the federal regulatory requirements for a home and community-based setting and include, but are not limited to, single family homes, duplexes, apartments, and congregate settings serving three or fewer unrelated individuals. Settings criteria will meet the requirements of 42 CFR 441.530. CFC participants may receive services in the workplace or other community settings.

viii. Qualifications of Providers of CFC Services

A. In accordance with CFR 441.565 (a)(1)-(3):
    1. An individual retains the right to train attendant care providers in the specific areas of attendant care needed by the individual, and to have the attendant care provider perform the needed assistance in a manner that comports with the individual's personal, cultural, and/or religious preferences.
    2. An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.
    3. Individuals also have the right to access other training provided by or through the State so that their attendant care provider(s) can meet any additional qualifications required or desired by individuals.

B. Provider qualifications for both the agency and self-directed model have been designed to ensure necessary safeguards to protect the health and welfare of participants. Personal Assistance agencies may include providers certified by the Office of Health Care Quality as a residential services agency (RSA) or certified by the Department as a Medicaid personal care provider agency, a Medicaid in-home aide program, or a public or private agency which employs in-home attendants and has been approved by the Department of Human Resources and enrolled with the Medicaid program to provide personal assistance services. Personal Assistance agencies are required to meet all licensing and/or certification standards mandated by the Office of Health Care Quality.
    1. Agency-based personal assistants are required to be certified in the performance of First Aid and CPR by a nationally recognized agency.

2. Agency-based personal assistants must be at least 18 years of age and be legally eligible for employment rendering personal assistance services in the State.
3. Agency-based personal assistants must be able to communicate, read, write, and follow directions in English.
4. Agency-based personal assistants must receive instruction, training and assessment from the delegating nurse regarding all services identified in the plan of services. Agency attendants shall receive instruction and supervision from the nurse monitor in accordance with the regulation requirements located at COMAR 10.09.84.20.
5. Certified Nursing Assistant status may be required for activities that would normally be delegated by a nurse; or, if required to administer medications, be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04.
6. Personal assistants may not have been convicted of, received a probation before judgment for, or entered a plea of nolo contendere to, a felony or any crime involving moral turpitude or theft, or have any other criminal history that indicates behavior which is potentially harmful to participants; may not be cited on the Maryland Geriatric Nursing Assistants Registry or any other registries with a determination of abuse, misappropriation of property, or neglect.
7. Personal assistance agencies are required to maintain accounts in order to receive criminal background investigation updates in the event that an employee is convicted of a crime after employment. CFC participants may not elect to waive any qualifications for Agency-based personal assistants. Agencies are required to maintain accounts with the Criminal Justice Information System (CJIS) in Maryland and must verify that all personal assistants have complied with criminal background check requirements (see COMAR 10.09.84.06) before assigning them to work with a CFC participant.
8. All CFC services providers must meet the "general requirements" for participation located at COMAR 10.09.84.05.
9. Enrolled personal assistance agencies are required to ensure that their attendants meet the applicable standards prior to working with CFC participants.

C. Unless the participant elects to waive these requirements, non-agency personal assistance providers are required to meet all criteria listed in item a. 1-6, above, for agency providers.

D. Under the self-directed model, the participant may waive these criteria.
   1. When a participant requests to waive provider qualifications, including a criminal background investigation, the results of the criminal background investigation, CPR, First Aid, the age limit or the requirement to communicate in English, they submit a form to the Department for approval or denial. The form is then signed

and returned to the participant with a summary of fair hearing rights. The Department retains the document in the participant file and mails or faxes a copy to the participant and the Supports Planner. When a requirement is waived, the provider is restricted to providing services to only the participant that requested the waiver.

2. The minimum requirement for a personal assistance provider for whom their participant (employer) has waived criteria would be for them to be eligible for employment rendering personal assistance services in the State.
3. When the age limit is waived, the attendant may be no younger than 16 years old and they must have an approved work permit consistent with state law.
4. When a participant elects to waive nurse monitoring, they may only waive nurse monitoring that is above the Department's minimum guidelines for nurse monitoring twice per year.
5. Providers convicted of fraud are excluded under federal regulations as specified in 42 CFR §1001.101 and those convicted of elder and specified child abuse are also excluded as allowed under federal law pursuant to 42 CFR 1002.2. The participant may waive the results of the background check, and hire their provider of choice regardless of any felony convictions other than those listed above.
6. The Department reserves the right to review the participant's ability to continue to use the self-direction model when there are concerns about the health and safety of the participant.

E. For both the agency and the self-directed models with service budget, per 42 CFR 441.540(a)(1), the person-centered planning process shall include representatives chosen by the individual.

ix. Quality Assurance and Improvement Plan

Provide a description of the State's Community First Choice quality assurance system. Please include the following information:

- **How the State will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement;**

A. Community First Choice will adopt the waiver Quality Management Strategy where appropriate.

B. CFC will have a Quality Management Strategy designed to review operations on an on-going basis, discover issues with operations, remediate those issues, and develop quality improvement initiatives to prevent the repeat of operational problems. The State Medicaid Agency oversees a cross-agency quality committee called the Waiver Quality

Council. The Waiver Quality Council meets regularly to address quality issues through data analysis, share program experiences and information, and further refine the waivers' quality management systems. Since many waiver participants receive CFC services as an integral part of their overall plan of service, CFC will be a part of the Waiver Quality Council.

C. Regular reporting and communication among the Office of Health Services, providers, the utilization control agent and other stakeholders, including the Community Options Advisory Council, which includes both the Community First Choice Implementation Council and Waiver Advisory Councils, and Waiver Quality Council, facilitates ongoing discovery and remediation. The Office of Health Services is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis and the formulation of recommendations for system improvements. Partners include, but are not limited to, the Office of Health Care Quality (OHCQ), providers, participants, family, Community Options Advisory Council, and the Waiver Quality Council. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which may include stakeholders.

D. When program data are received, it is documented by OHS staff. Data sources include, but are not limited to, provider enrollment documents, provider and participant audits, the provider database, the tracking system, Quality Care Review Team (QCR) reviews, reportable events submissions and other reporting. Data are assigned to appropriate staff to be reviewed, prioritized and recorded in the appropriate trends and anomalies that may need immediate attention. Plans developed as a result of this process will be shared with stakeholders for review and recommendation for remediation.

E. In accordance with the Department's Reportable Events Policy, all entities associated with Community First Choice are required to report alleged or actual Reportable Events. All Reportable Events shall be reported in full on the Department's newly designed Reportable Events form in the tracking system, analyzed via reports and through the Quality Council process to analyze trends and identify areas in need of improvement.

F. Any person who believes that an individual has been subjected to abuse, neglect, or exploitation in the community or an assisted living facility is required to report the alleged abuse, neglect, or exploitation immediately to an Adult Protective Services (APS) or Child Protective Services (CPS) office and, within 24 hours, the Office of Health Services.

G. The supports planners will have access to a check list for any residents in congregate

settings in order to ensure the setting meets HCBS settings requirements. The supports planner will be able to utilize this form during any of their quarterly visits with participants where there is a residence change or there is a change in living situation of the current residence. They will be required, at least annually, to submit this form in the tracking system to the State. The State will be responsible for oversight during Plan of Service review and during annual audits of this information.

- **The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.**

H. Performance Measures:

1. The State has instituted the interRAI HC as the standardized assessment instrument for CFC. The interRAI HC captures information about support needs and along with the tracking system, maintains a database of all applicants and participants. All historical data can be retrieved easily by ad hoc reporting. Reports are available on measures such as number of applicants receiving an annual assessment, number of participants in each RUG category, and other measures which can be sorted by time frame, assessor, by jurisdiction, and other criteria. The Department can evaluate the timeliness of the local health departments completing the assessments, the Utilization Control Agent in completing their reviews, and of various tasks of the Supports Planners.
2. The Department will work with its Quality Care Review (QCR) team to increase the overall scope and effectiveness of the program. The Department has included QCR in LTSSMaryland to track quality indicators of providers and will expand the quality review process to include participant-indicators.
3. The Department will also be adding a Reportable Events module to LTSSMaryland to enhance and coordinate reviews of incidents and track information in one uniform system.

I. Outcomes Measures

Another benefit to utilizing the standardized interRAI assessment tool is access to quality data reports to track long term changes in medical status and needs of participants. The interRAI tool is equipped to track data across years and report based on aggregate data by jurisdiction or program as well as tracking individual participant outcomes and changes throughout time. The Department will also use Resource Utilization Groups (RUGs) based on the interRAI assessment to identify level of need and track improvement over time.

J. Satisfaction Measures

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The State has chosen to implement the Money Follows the Person (MFP) Quality of Life survey amended with several questions from the Participant Experience Survey (PES). These questions will be asked directly to participants to determine level of satisfaction with the CFC program. The State will utilize the services of an independent contractor to perform these surveys with CFC participants, thus avoiding conflict of interest.

- **Describe how the State's quality assurance system will measure individual outcomes associated with the receipt of community-based attendant services and supports.**

K. Administering CFC and quality staff will continuously evaluate the effectiveness and relevance of the quality improvement strategy with input from participants, providers, and other stakeholders. Through the continuous process of discovery, vital information will be presented to the Department through various sources, such as the Reportable Events listed above, provider licensure, complaint surveys/reports, and provider audits. In addition to that list, the Department will also utilize interRAI quality data reports to track long term changes. The interRAI tool is equipped to track data across years and report based on needs. Clinical Assessment Protocols will help enhance service plans and ensure necessary services are provided and coordinated properly. The Department will also use Resource Utilization Groups (RUGs) to identify level of need and track improvement over time.

L. The State will utilize the tracking system to monitor participants' service plans in order to ensure that services are delivered in accordance with the service plan.

M. Included on the POS are the participant's strengths and goals. Progress on individual goals will be monitored and reported by the Supports Planner during quarterly and annual visits. Tracking system reports will allow data to be aggregated and analyzed.

- **Describe the system(s) for mandatory reporting, investigation and resolution of allegations of neglect, abuse, and exploitation in connection with the provision of CFC services and supports.**

N. In the case of suspected neglect, abuse, or exploitation in the CFC program, the Department maintains the same procedure as has been documented in the Reportable Events (RE) Policy used by the home and community-based waivers. "Any person who believes that an individual has been subjected to abuse, neglect, or exploitation in the community or an assisted living facility is required to report the alleged abuse, neglect, or exploitation immediately to an Adult Protective Services (APS) or Child Protective Services (CPS) office and, within 24 hours, the Office of Health Services." As

determined by the RE Policy, all reportable events that are suspected neglect, abuse, or exploitation would be considered cases of Immediate Jeopardy (IJ). In addition to being reported to the appropriate agency, these cases are monitored by the Office of Health Services to meet timely resolution. Each case will be reviewed by OHS staff.
The Department also maintains a web-based tracking system for many long-term supports and services. This system tracks all CFC activities and is called the LTSSMaryland tracking system. Supports planning providers, nurse monitors, the fiscal intermediary contractor, and the utilization control agent will all use the system to document aspects of their work. The tracking system will be used to document activities, complete forms such as monthly contacts and reportable events, and enter other data used for reporting.

- **Describe the State's standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered service plan.**

O. The supports planning provider shall meet with the participant in-person at least once every 90 days to monitor the implementation of the POS and identify any unmet needs. These minimum contact standards may be waived by the participant and therefore the participant may identify unmet needs in their POS via a consumer portal to the tracking system. If there is a needed or requested change in the POS, the provider or participant, shall follow Departmental guidelines to submit a POS modification request and assist the participant in changing his or her services.

P. Participants who are denied services receive a letter, including Notice of Fair Hearing and Appeal Rights, from the State. The letter lists the reason(s) for the denial and provides detailed information about steps for the individual/representative to follow, as well as time frames, to request an appeal. The letter includes information regarding procedures to follow to assure continuance of benefits while the appeal process is underway. The letter is mailed to the applicant and their representative, if designated, by the State. The independent Office of Administrative Hearings (OAH) sends the appellant/representative information regarding the date and time of the hearing. An information sheet is enclosed with the hearing notice which explains the nature of administrative hearing and what to expect, what documents an individual may want to bring, how to access the OAH law library and the right to be represented by a friend, relative or an attorney (information on obtaining legal representation for low income individuals is provided). Additionally, this information sheet instructs the appellant on how to obtain special accommodations such as an interpreter, and conditions under which an appellant may request a postponement.

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Q. Participants and/or their representatives may request assistance applying for a Fair Hearing from a provider, supports planner or other individual of their choosing. Information sent with the adverse action notice also includes contact information related to Legal Aid and the Maryland Disability Law Center, the State's Protection and Advocacy Agency.

- **Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.**

R. Voluntary training on self-direction will be offered to participants through an agreement with the Maryland Department of Disabilities. This training will be available when a participant who wishes to self direct, requests assistance with subjects such as hiring, firing, and managing employees, as described above in *iii. Service Package, A.3.Voluntary Training.*

S. Supports Planning will also educate participants about consumer independence and control and provide information about the provisions of quality improvement and assurance as described above in *iii. Service Package, A.4 Support System.* Supports Planners will assist the participants in accessing training on self-direction, selecting providers of consumer training services, and in learning how to navigate the Consumer portal of the LTSS tracking system. Participants may monitor provider time keeping, view reports, and access and update their POS through the tracking system.

T. In Home Supports Assurance System (ISAS) –A telephonic time keeping system that will track personal assistance and nurse monitoring hours and use a landline phone or one-time password device to ensure that a provider is in the participant's home when clocking in and out. Participants may view and monitor the time keeping of their providers in this system.

S. The CFC Implementation Council will remain to be a consumer majority committee that will advise the State Medicaid Agency on ongoing issues and procedures of the CFC program.

- **Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.**

T. The CFC Council has met more than 20 times in the past year and half to aid the State in developing this new Program. After the implementation of CFC, the State will continue to have a consumer-majority advisory council. The council will have the

opportunity to meet at least quarterly. The State welcomes other stakeholders and advocates to attend these meetings either in person or via conference call/webinar format.

- **The methods used to continuously monitor the health and welfare of Community First Choice individuals**

U. The health and welfare of CFC individuals will be monitored by all of the previously mentioned standards in performance and outcome measurements including via nurse monitoring visits, Supports Planning contacts, and Reportable Events. The State will use all available information in the standardized assessment and reporting capabilities of the tracking system to monitor health services for participants.

- **The methods for assuring that individuals are given a choice between institutional and community-based services.**

V. A person-centered planning process will begin before the choice of an identified supports planner. Materials will be mailed to applicants on all available supports planning agencies by jurisdiction. This will include information on all resources and services available. Upon entrance into the Program, the participant will be able to select their Supports Planner, and the level of self direction with which they would like to pursue. It will be the responsibility of supports planners to counsel an individual on their choice between receiving institutional and community-based services. Activities of the Supports Planner will be entered in the tracking system and monitored via automated reports.

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1915 – K Community First Choice State Plan Option Reimbursement

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both government and private providers of services provided under the Community First Choice Option. The agency's fee schedule is effective for services provided on or after January 6, 2014. All rates are published at:
https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Community%20First%20Choice.aspx.

The following 1915(k) provider types are reimbursed in the manner described:

I. State Plan Services

A. Personal Assistance Services: Rates are established using several factors. Preexisting rates across programs, collective bargaining with the Union, and the State's budget are all considered. Payment is based upon the total yearly budget established for personal assistance services for each participant as outlined per attachment 3.1 - K, page 3. Participants choosing to self direct will be able to set their rate, for independent providers, within a prescribed range. Providers of this service use a call-in system to clock in and out. Billing occurs based on an electronic claim generated by the call-in system in 15 minute increments. All rates and rate ranges are defined in the above fee schedule.

B. Nurse Monitoring: The rate was developed based on preexisting rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at http://dbm.maryland.gov/Pages/home.aspx. As local health departments are sole providers of this service, in accordance with a 1915(b) waiver, one rate has been published for this service. Frequency for this service is established using criteria from the Maryland Nurse Practice Act. Billing occurs in 15 minute increments for this service.

C. Consumer Training: The rate was based on existing rates for the service. Billing occurs in 15 minute increments for the service provided to the participant.

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D. Personal Emergency Response System: The rate was based on existing rates for the service. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the participant's Plan of Service.

E. Supports Planning: The rate was developed based on pre-existing rates across programs. The State also used rate comparisons of state salaries listed on the Department of Budget and Management website located at http://dbm.maryland.gov/Pages/home.aspx. All providers of this service will be reimbursed at the same rate. Billing occurs in 15 minute increments for this service.

F. Financial Management Service: As defined per 42 CFR 441.545(b)(1), financial management activities must be made available to individuals with a service budget. The financial management entity is procured through state procurement regulations associated with competitive bidding.

II. Non-State Plan CFC Services

a. The following will be services permissible under CFC in the category of items that substitute for human assistance:

i. Home delivered meals

a. Providers of this service are limited to those listed on page 6 of attachment 3.1 - K.
b. This service will be provided to the extent that it substitutes for human assistance and, along with personal assistance, is limited by the RUG allocated budget .
c. Meals are reimbursed based on the Department's fee schedule per meal and cannot exceed 2 meals daily.

ii. Accessibility Adaptations

a. Providers of this service are limited to those listed on page 7 of attachment 3.1 - K.
b. A unit is equal to one piece of equipment or item.
c. Reimbursement occurs on a fee for service basis, based on the rate in the fee schedule, and each assessment is one unit of service.
d. This expense will be capped at $15,000 for every three year period per participant.

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iii. Environmental Assessments
   a. Providers of this service are limited to those listed on page 7 of attachment 3.1 - K.

iv. Technology that substitutes for human assistance
   a. A unit is equal to one piece of equipment or item.
   b. Included technology items are listed on page 7 of attachment 3.1 - K
   c. The department will approve, for items costing more than $1,000, based on multiple quotes from supports planners.
   d. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.
   e. Supports Planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed $1,000. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan.
   f. CFC may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the on-going cost of care or avert institutional care. Units of service may not exceed what is approved in the participant's plan of service.

III. Transition Services – State Plan Service
   a. The provider of the service is limited by the state's fiscal intermediary contract.
   b. Transition services will be covered when it is identified based on assessment of need and listed as a needed service in the participant's Recommended Plan of Care.
   c. CFC transition services may be administered up to 60 calendar days post transition.
   d. Transition services are limited to $3,000 per transition.